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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 40864

LED JAN 24 1942

Registration District No. 399 | Primary Registration District No. 1002 | Registrar's No. 4540

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County: Jackson
(b) City or town: Kansas City
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 505 East 24 Terrace
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ____ (Specify whether years, months or days)
In this community: 20 years

2. USUAL RESIDENCE OF DECEASED:
(a) State: Missouri (b) County: Jackson
(c) City or town: Kansas City
(If outside city or town limits, write "RURAL")
(d) Street No.: 505 East 24 Terrace
(If rural, give location)
(e) If foreign born, how long in U. S. A.? D years.

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3. (a) PRINT FULL NAME: Willard Alfred Mohler

3. (b) If veteran, name war: no

3. (c) Social Security No.: no

4. Sex: Male 0

5. Color or race: White

6. (a) Single, widowed, married, divorced: Widowed

6. (b) Name of husband or wife: Velma Mohler

6. (c) Age of husband or wife if alive: ____ years

7. Birth date of deceased: August 21, 1883 (Month) (Day) (Year)

8. AGE: Years 58 | Months 4 | Days 3 | If less than one day ____ hr. ____ min.

9. Birthplace: St. Joseph, Missouri (City, town, or county) (State or foreign country) U

10. Usual occupation: Laborer

11. Industry or business: ____

MOTHER FATHER
12. Name: Calvin Mohler
13. Birthplace: Blocken, Iowa (City, town, or county) (State or foreign country) i

MOTHER
14. Maiden name: Mary Elizabeth ---
15. Birthplace: Mount-Air, Iowa (City, town, or county) (State or foreign country) 1

16. (a) Informant: Mrs. Mary E. Mohler
(b) Address: 505 East 24 Terr.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: 12/8/41 (Month) (Day) (Year)
(c) Place: burial or cremation: Floral Hills Cemetery

18. (a) Signature of funeral director: Zurk & Tolin Co.
(b) Address: K. C., Mo.

19. (a) Dec 8, 1941 (Date received local registrar) (b) M. M. Crowe (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month 12 day 5-41 year ____ hour ____ minute 9:25 A.M.

21. I hereby certify that I attended the deceased from ____, 19____, to ____, 19____; that I last saw him alive on ____, 19____; and that death occurred on the date and hour stated above.

Duration

Immediate cause of death: Generalized Cirrhosis

Due to: Chronic Interstitial Nephritis

Due to: Coronary Sclerosis 9 yrs

Other conditions (Include pregnancy within 3 months of death):

Major findings:
Of operations:
Of autopsy:

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work?
(e) Means of injury:

23. Signature: ____ (M. D. or other)
Address: ____ Date signed: ____

(Licensed Embalmer's Statement on Reverse Side)

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by John J. Conroy, Registered Apprentice No. 307 working under my personal supervision.

Signed Charles M. Quinn

Licensed Embalmer No. 3634

P. O. Address K. C. Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wit the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.